

# ACGME Program Requirements for Graduate Medical Education in Urology

*Common Program Requirements are in BOLD*

*Effective: July 1, 2009*

## Introduction

### Int.A. Definition of the Specialty

Urology is the specialty that evaluates and treats patients with disorders of the genitourinary tract, including the adrenal gland. Specialists in this discipline must demonstrate knowledge of the basic and clinical sciences related to the normal and diseased genitourinary system as well as attendant skills in medical and surgical therapy. Residency programs must educate physicians in the prevention and treatment of genitourinary disease, including the diagnosis, medical and surgical management, and reconstruction of the genitourinary tract.

### Int.B. Duration and Scope of Education

Int.B.1. The prerequisite for admission to a urology residency program is a minimum of one year of an Accreditation Council for Graduate Medical Education (ACGME)-accredited surgery program. Based on educational objectives, two years of general surgery is an alternative format. During these one or two years, residents must spend a minimum of three months in general surgery as well as a minimum of three months in the core surgical rotations of critical care, vascular surgery, or trauma. Additional clinical assignments, not including dedicated research time, must enhance the resident education and prepare residents for the practice of urology. The educational program for the general surgery period is developed by the program director of the respective surgery residency program with the input and approval of the respective urology program director.

Int.B.2. A minimum of 48 months of clinical urology education is required. Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. The clinical and academic experience as a chief resident should prepare the resident for an independent practice of urology. As such, this Chief Resident experience should include management of patients with complex urologic disease, advanced procedures, and, with appropriate supervision, a high level of responsibility and independence.

## I. Institutions

### I.A. Sponsoring Institution

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.**

**The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her**

**educational and administrative responsibilities to the program.**

**I.B. Participating Sites**

**I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**I.B.1.a) The PLA should:**

**I.B.1.b) identify the faculty who will assume both educational and supervisory responsibilities for residents;**

**I.B.1.c) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

**I.B.1.d) specify the duration and content of the educational experience; and,**

**I.B.1.e) state the policies and procedures that will govern resident education during the assignment.**

**I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

**I.B.3. Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary, all participating sites must demonstrate the ability to promote the program goals.**

**I.B.3.a) The inclusion of more than four participating sites is an exception, and is not acceptable unless based on sound educational rationale and approved in advance by the Review Committee. Two or more residents should rotate to each participating site to maintain peer-interaction, unless special resources are offered.**

**I.B.3.b) Assignments to distant sites must be justified on the basis of educational resources that are not available at the sponsoring institution.**

**II. Program Personnel and Resources**

**II.A. Program Director**

**II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring**

**institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

- II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.2.a) The program director should continue in his or her position for a minimum of six years. An absence of three months or more must be reported to the Review Committee.**
- II.A.3. Qualifications of the program director must include:**
- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
- II.A.3.b) current certification in the specialty by the American Board of Urology, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.3.c) current medical licensure and appropriate medical staff appointment.**
- II.A.3.d) documented clinical and scholarly expertise in Urology that should be apparent from the program director's curriculum vitae.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
- II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
- II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
- II.A.4.c) approve the selection of program faculty as appropriate;**
- II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
- II.A.4.e) monitor resident supervision at all participating sites;**
- II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**

- II.A.4.g)** provide each resident with documented semiannual evaluation of performance with feedback;
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion;
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
  - II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty;
  - II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
  - II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
  - II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
  - II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
  - II.A.4.n).(2)** changes in resident complement;

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| <b>II.A.4.n).(3)</b>  | <b>major changes in program structure or length of training;</b>   |
| <b>II.A.4.n).(4)</b>  | <b>progress reports requested by the Review Committee;</b>   |
| <b>II.A.4.n).(5)</b>  | <b>responses to all proposed adverse actions;</b>  |
| <b>II.A.4.n).(6)</b>  | <b>requests for increases or any change to resident duty hours;</b>  |
| <b>II.A.4.n).(7)</b>  | <b>voluntary withdrawals of ACGME-accredited programs;</b>   |
| <b>II.A.4.n).(8)</b>  | <b>requests for appeal of an adverse action;</b>   |
| <b>II.A.4.n).(9)</b>  | <b>appeal presentations to a Board of Appeal or the ACGME; and,</b>  |
| <b>II.A.4.n).(10)</b> | <b>proposals to ACGME for approval of innovative educational approaches.</b>   |
| <b>II.A.4.o)</b>      | <b>obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:</b>   |
| <b>II.A.4.o).(1)</b>  | <b>program citations, and/or</b>   |
| <b>II.A.4.o).(2)</b>  | <b>request for changes in the program that would have significant impact, including financial, on the program or institution.</b>  |
| <b>II.A.4.p)</b>      | ensure that the operative procedures performed by residents are entered in the ACGME case-log system. Annually and at graduation, the program director is responsible for reviewing the logs of each resident. These annual and final logs must be signed by both the resident and the program director as a statement of its accuracy. Upon graduation, the program director is responsible for submitting each resident's final aggregate log of the urology years to the ACGME; |
| <b>II.A.4.q)</b>      | conduct and document ongoing and final reviews of operative logs with residents to ensure an even distribution, volume, and variety of operative experiences;  |
| <b>II.A.4.r)</b>      | notify each resident in writing, prior to admission of the required length of the educational program, including both accredited and non-accredited time. The educational program's required length may not be changed without mutual agreement with the resident, unless there is a significant break in his or her educational program or unless the resident requires remedial education. All educational program length changes for any resident must be                       |

approved in advance by the Review Committee;

II.A.4.s) ensure that the didactic conferences include:

II.A.4.s).(1) combined morbidity and mortality conferences for all participating sites;

II.A.4.s).(2) urological imaging conferences;

II.A.4.s).(3) urological pathology conferences;

II.A.4.s).(4) journal review.

II.A.4.t) maintain a list of conferences and have this list available for review at the time of a site visit. The list should include the conference topic, the name of the presenter(s) and the names of the faculty and residents present. Conferences must be well-attended by residents and faculty and attendance must be documented.

## **II.B. Faculty**

**II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

**The faculty must:**

**II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

**II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

**II.B.2. The physician faculty must have current certification in the specialty by the American Board of Urology, or possess qualifications acceptable to the Review Committee.**

II.B.2.a) To provide a diverse educational experience, several faculty members should have subspecialty education and concentrate their practice in one or more of the following urological domains: voiding dysfunction, female urology, reconstruction, oncology, calculus disease, pediatrics, sexual dysfunction and infertility. In addition, the faculty should have experience with the following urologic techniques: endo-urology, minimally-invasive intra-abdominal and pelvic surgical techniques (e.g., laparoscopy/robotics), major flank and pelvic surgery, urologic imaging, and microsurgery. Ideally, residents should have clinical

interaction with faculty having expertise in geriatrics, infectious disease, renovascular disease, renal transplantation, trauma, interventional radiology, plastic surgery, and medical oncology.

- II.B.2.b) In addition to the program director, there must be at least two clinical urology faculty devoting sufficient time to supervise and teach the residents, and who are committed fully to the educational objectives of the residency program. A faculty-to-resident ratio of at least 1:2 in the total program is required. The program director may be counted as one of the faculty in determining the ratio. The program director must notify the Review Committee if the number of clinical urology faculty members drops below three, or if the ratio falls below 1:2 and remains below that level longer than one year.
- II.B.2.c) The program director is responsible for the appointment of a local site director who must:
- II.B.2.c).(1) be a urologist in good standing at the participating site and have the majority of his or her practice at that site;
- II.B.2.c).(2) be responsible for the education of the residents at the participating site;
- II.B.2.c).(3) be responsible for the supervision of all educational and clinical activities of the program at that site.
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
- II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
- II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1) **peer-reviewed funding;**
- II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
- II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**

**II.B.5.b).(4) participation in national committees or educational organizations.**

**II.B.5.c) Faculty should encourage and support residents in scholarly activities.**

**II.C. Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

**II.D. Resources**

**The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.**

**II.D.1.** There must be adequate space and equipment for the educational program, including meeting rooms and classrooms with audiovisual and other educational aids; office space for staff; diagnostic, therapeutic, and research facilities; and outpatient facilities, clinic, and office space accessible to residents for preoperative evaluation and postoperative follow-up.

**II.D.2.** Clinical facilities must contain state-of-the-art equipment to perform diagnostic and therapeutic procedures. Equipment to perform the following procedures must be available: flexible cystoscopy, ureteroscopy, percutaneous endoscopy, percutaneous renal access, extracorporeal shock wave lithotripsy, ultrasonography and biopsy, fluoroscopy, laparoscopy, laser therapy. Urodynamic evaluation equipment should be present. Video imaging should be available to allow adequate supervision and education during endoscopic procedures.

**II.D.3.** A sufficient number and variety of inpatient and ambulatory adult and pediatric patients with urologic disease must be available for resident education.

**II.E. Medical Information Access**

**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.**

**III. Resident Appointments**

**III.A. Eligibility Criteria**

**The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**



### **III.B. Number of Residents**

**The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.**

- III.B.1. Any change in the number of residents, whether permanent or temporary, must receive prior approval of the Review Committee. Requests for changes in the resident complement of a program must be based on a strong educational rationale. A vacancy in a resident complement, if filled, must be at the same level in which the vacancy occurs, unless otherwise approved by the Review Committee.

### **III.C. Resident Transfers**

- III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**

- III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**

### **III.D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

- III.D.1. A log that details the operative experience of all fellows as well as an impact statement must be submitted with the urology resident operative logs at the time of the site visit. If a program's resident rotates to a participating site that offers a urologic fellowship program, an impact statement and operative log of the fellow(s) from the participating site must be available at the time of the program review.

## **IV. Educational Program**

- IV.A. **The curriculum must contain the following educational components:**

- IV.A.1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

- IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to**

**residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**

**IV.A.3. Regularly scheduled didactic sessions;**

**IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

**IV.A.5. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**IV.A.5.a) Patient Care**

**Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:**

IV.A.5.a).(1) must be provided with experience in direct patient care with increasing levels of responsibility in patient management as they advance through the program;

IV.A.5.a).(2) should have responsibility under supervision for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications;

IV.A.5.a).(3) must participate in the continuity of patient care through preoperative and postoperative clinics and inpatient contact. When residents participate in preoperative and postoperative care in a clinic or private office setting, the program director must ensure that the resident functions with an appropriate degree of responsibility under supervision;

IV.A.5.a).(4) should be given responsibility based upon the individual resident's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's status.

**IV.A.5.b) Medical Knowledge**

**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:**

IV.A.5.b).(1)	must have didactic instruction that includes the following core domains:
IV.A.5.b).(1).(a)	voiding dysfunction
IV.A.5.b).(1).(b)	female urology
IV.A.5.b).(1).(c)	reconstruction
IV.A.5.b).(1).(d)	oncology
IV.A.5.b).(1).(e)	calculus disease
IV.A.5.b).(1).(f)	pediatrics
IV.A.5.b).(1).(g)	reproductive and sexual dysfunction
IV.A.5.b).(2)	must receive instruction in the following core techniques:
IV.A.5.b).(2).(a)	endo-urology
IV.A.5.b).(2).(b)	minimally-invasive intra-abdominal and pelvic surgical techniques (e.g., laparoscopy/robotics)
IV.A.5.b).(2).(c)	major flank and pelvic surgery
IV.A.5.b).(2).(d)	perineal and genital surgery
IV.A.5.b).(2).(e)	urologic imaging including fluoroscopy, interventional radiology, and ultrasound
IV.A.5.b).(2).(f)	microsurgery
IV.A.5.b).(3)	must receive instruction in:
IV.A.5.b).(3).(a)	bioethics
IV.A.5.b).(3).(b)	radiation safety
IV.A.5.b).(3).(c)	biostatistics
IV.A.5.b).(3).(d)	epidemiology
IV.A.5.b).(3).(e)	geriatrics
IV.A.5.b).(3).(f)	infectious disease
IV.A.5.b).(3).(g)	renovascular disease
IV.A.5.b).(3).(h)	renal transplantation

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| IV.A.5.b).(3).(i) | trauma           |
| IV.A.5.b).(3).(j) | plastic surgery  |
| IV.A.5.b).(3).(k) | medical oncology |

**IV.A.5.c) Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

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| IV.A.5.c).(1) | identify strengths, deficiencies, and limits in one's knowledge and expertise;  |
| IV.A.5.c).(2) | set learning and improvement goals;   |
| IV.A.5.c).(3) | identify and perform appropriate learning activities;   |
| IV.A.5.c).(4) | systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; |
| IV.A.5.c).(5) | incorporate formative evaluation feedback into daily practice;  |
| IV.A.5.c).(6) | locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;                   |
| IV.A.5.c).(7) | use information technology to optimize learning; and,   |
| IV.A.5.c).(8) | participate in the education of patients, families, students, residents and other health professionals.                         |

**IV.A.5.d) Interpersonal and Communication Skills**

**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:**

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| IV.A.5.d).(1) | communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; |
| IV.A.5.d).(2) | communicate effectively with physicians, other health professionals, and health related agencies;  |

- IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.d).(4)** act in a consultative role to other physicians and health professionals; and,
- IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical records, if applicable.

**IV.A.5.e) Professionalism**

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:**

- IV.A.5.e).(1)** compassion, integrity, and respect for others;
- IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-interest;
- IV.A.5.e).(3)** respect for patient privacy and autonomy;
- IV.A.5.e).(4)** accountability to patients, society and the profession; and,
- IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

**IV.A.5.f) Systems-based Practice**

**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:**

- IV.A.5.f).(1)** work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- IV.A.5.f).(2)** coordinate patient care within the health care system relevant to their clinical specialty;
- IV.A.5.f).(3)** incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

- IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;**
- IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.**

#### **IV.B. Residents' Scholarly Activities**

**IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**

**IV.B.2. Residents should participate in scholarly activity.**

IV.B.2.a) Documentation of resident performance of scholarly activity may be demonstrated by manuscript preparation, lectures, teaching activities, abstracts, and active performance of research or participation in clinical studies and reviews.

IV.B.2.b) Research (up to six months in duration) may be included in the clinical years, provided the resident has regular clinical duties concurrent with the research assignment.

**IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

### **V. Evaluation**

#### **V.A. Resident Evaluation**

##### **V.A.1. Formative Evaluation**

**V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

- V.A.1.b).(3)** document progressive resident performance improvement appropriate to educational level; and,
- V.A.1.b).(4)** provide each resident with documented semiannual evaluation of performance with feedback.

The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

**V.A.2. Summative Evaluation**

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

- V.A.2.a)** document the resident's performance during the final period of education, and
- V.A.2.b)** verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

**V.B. Faculty Evaluation**

- V.B.1.** At least annually, the program must evaluate faculty performance as it relates to the educational program.
- V.B.2.** These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.B.3.** This evaluation must include at least annual written confidential evaluations by the residents.

**V.C. Program Evaluation and Improvement**

- V.C.1.** The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
  - V.C.1.a)** resident performance;
  - V.C.1.b)** faculty development;
  - V.C.1.c)** graduate performance, including performance of program graduates on the certification examination; and,
  - V.C.1.d)** program quality. Specifically:

**V.C.1.d).(1)** Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

**V.C.1.d).(2)** The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

**V.C.2.** If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

## **VI. Resident Duty Hours in the Learning and Working Environment**

### **VI.A. Principles**

**VI.A.1.** The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

**VI.A.2.** The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

**VI.A.3.** Didactic and clinical education must have priority in the allotment of residents' time and energy.

**VI.A.4.** Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

### **VI.B. Supervision of Residents**

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

### **VI.C. Fatigue**

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

### **VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent



away from the duty site.

- VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- VI.D.2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.
- VI.D.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
- VI.E. On-call Activities
  - VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
  - VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
  - VI.E.3. No new patients may be accepted after 24 hours of continuous duty.
  - VI.E.4. At-home call (or pager call)
    - VI.E.4.a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
    - VI.E.4.b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
    - VI.E.4.c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- VI.F. Moonlighting
  - VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
  - VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

**VI.G. Duty Hours Exceptions**

**A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**

**VI.G.1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**

**VI.G.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

**VII. Experimentation and Innovation**

**Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

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